

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017292

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 3/6Primary Registration District No. ---Registrar's No. 178

FILED MAY 15 1963

VS 300
Rev. 4/59

1 0940

2 0945

3 2

4 1

5 1

6

7 0

8 2

9 332X

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11

12 86-2

13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Francios</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francios</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington - RURAL</u> | | c. CITY OR TOWN <u>Farmington, Mo.</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Thomas Dell Mem. Home</u> | | d. STREET ADDRESS (If outside, give location) <u>Rural Route</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Leota Mitchell</u> | | 4. DATE OF DEATH Month Day Year <u>April 30 1963</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/19/1875</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>87</u> |
| 11a. FATHER'S NAME <u>William J. Level</u> | | 11b. MOTHER'S MAIDEN NAME <u>Emma Shannon</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address <u>Mrs. Mae Blaylock Farmington, Mo.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive circulatory failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Thrombotic Encephalomalacia + prolonged secondary</u> | |
| | | DUE TO (c) <u>Arteriosclerosis</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>4-28-63</u> to <u>4-28-63</u> and last saw her alive on <u>4-28-63</u> Death occurred at <u>1:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>M. Leota Mitchell</u> | | 22b. ADDRESS <u>Farmington Mo</u> | 22c. DATE SIGNED <u>5-1-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May, 2/1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Park View Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Farmington Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>C.H. Cozean Farmington Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>May 1, 1963</u> | 26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u> |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

MAY 29 1963

MAY 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4084

P. O. Address Fernington Ms

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.